

BILL

ORIGINAL

YEAR

1 A bill to be entitled
 2 An act relating to Medicaid managed care; providing an
 3 effective date.

4
 5 Be It Enacted by the Legislature of the State of Florida:

6
 7 Section 1. Sections 409.961 through 409.992, Florida
 8 Statutes, are designated as part IV of chapter 409, Florida
 9 Statutes, entitled "Medicaid Managed Care."

10 Section 2. Section 409.961, Florida Statutes, is created
 11 to read:

12 409.961 Statutory construction; applicability; rules.—It
 13 is the intent of the Legislature that if any conflict exists
 14 between the provisions contained in this part and provisions
 15 contained in other parts of this chapter, the provisions
 16 contained in this part shall control. The provisions of ss.
 17 409.961-409.970 apply only to the Medicaid managed medical
 18 assistance program, long-term care managed care program, and
 19 managed long-term care for persons with developmental
 20 disabilities program, as provided in this part. The agency shall
 21 adopt any rules necessary to comply with or administer this part
 22 and all rules necessary to comply with federal requirements. In
 23 addition, the department shall adopt and accept the transfer of
 24 any rules necessary to carry out the department's
 25 responsibilities for receiving and processing Medicaid
 26 applications and determining Medicaid eligibility and for
 27 ensuring compliance with and administering this part, as those
 28 rules relate to the department's responsibilities, and any other

BILL

ORIGINAL

YEAR

29 provisions related to the department's responsibility for the
 30 determination of Medicaid eligibility.

31 Section 3. Section 409.962, Florida Statutes, is created
 32 to read:

33 409.962 Definitions.—As used in this part, except as
 34 otherwise specifically provided, the term:

35 (1) "Agency" means the Agency for Health Care
 36 Administration.

37 (2) "Aging network service provider" means a provider that
 38 participated in a home and community-based waiver administered
 39 by the Department of Elderly Affairs or the community care
 40 service system pursuant to s. 430.205, as of October 1, 2013.

41 (3) "Comprehensive long-term care plan" means a managed
 42 care plan that provides services described in s. 409.973 and
 43 also provides the services described in ss.409.980 or 409.988

44 (4) "Department" means the Department of Children and
 45 Families.

46 (5) "Developmental disability provider service network"
 47 means a provider service network, a controlling interest of
 48 which includes one or more entities licensed pursuant to s.
 49 393.067 or s. 400.962 with 18 or more licensed beds and which
 50 owner or owners have at least 10 years experience serving this
 51 population.

52 (6) "Direct care management" means care management
 53 activities that involve direct interaction with Medicaid
 54 recipients.

55 (7) "Eligible plan" means a health insurer authorized
 56 under chapter 624, an exclusive provider organization authorized

BILL

ORIGINAL

YEAR

57 under chapter 627, a health maintenance organization authorized
 58 under chapter 641, or a provider service network authorized
 59 under s. 409.912(4) (d). For purposes of the managed medical
 60 assistance program, the term also includes the Children's
 61 Medical Services Network authorized under chapter 391. For
 62 purposes of the long-term care managed care program, the term
 63 also includes entities qualified under 42 C.F.R. part 422 as
 64 Medicare Advantage Preferred Provider Organizations, Medicare
 65 Advantage Provider-sponsored Organizations, and Medicare
 66 Advantage Special Needs Plans, and the Program for All-Inclusive
 67 Care for the Elderly.

68 (8) "Long-term care plan" means a managed care plan that
 69 provides the services described in s. 409.980 for the long-term
 70 care managed care program or the services described in s.
 71 409.988 for the long-term care managed care program for persons
 72 with developmental disabilities.

73 (9) "Long term care provider service network" means a
 74 provider service network a controlling interest of which is
 75 owned by one or more licensed nursing homes, assisted living
 76 facilities with 17 or more beds, home health agencies, community
 77 care for the elderly lead agencies, or hospices.

78 (10) "Managed care plan" means an eligible plan under
 79 contract with the agency to provide services in the Medicaid
 80 program.

81 (11) "Medicaid" means the medical assistance program
 82 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.
 83 1396 et seq., and regulations thereunder, as administered in
 84 this state by the agency.

BILL

ORIGINAL

YEAR

85 (12) "Medicaid recipient" or "recipient" means an
 86 individual who the department or, for Supplemental Security
 87 Income, the Social Security Administration determines is
 88 eligible pursuant to federal and state law to receive medical
 89 assistance and related services for which the agency may make
 90 payments under the Medicaid program. For the purposes of
 91 determining third-party liability, the term includes an
 92 individual formerly determined to be eligible for Medicaid, an
 93 individual who has received medical assistance under the
 94 Medicaid program, or an individual on whose behalf Medicaid has
 95 become obligated.

96 (13) "Prepaid plan" means a managed care plan that is
 97 licensed or certified as a risk-bearing entity in the state and
 98 is paid a prospective per-member, per-month payment by the
 99 agency.

100 (14) "Provider service network" means an entity certified
 101 pursuant to s. 409.912(4)(d) of which a controlling interest is
 102 owned by a health care provider, or group of affiliated
 103 providers, or a public agency or entity that delivers health
 104 services. Health care providers include Florida-licensed health
 105 care professionals or licensed health care facilities, federally
 106 qualified health care centers, and home health care agencies.

107 (15) "Specialty plan" means a managed care plan that
 108 serves Medicaid recipients who meet specified criteria based on
 109 age, medical condition, or diagnosis.

110 Section 4. Section 409.963, Florida Statutes, is created
 111 to read:

BILL

ORIGINAL

YEAR

112 409.963 Single state agency.—The Agency for Health Care
 113 Administration is designated as the single state agency
 114 authorized to manage, operate, and make payments for medical
 115 assistance and related services under Title XIX of the Social
 116 Security Act. Subject to any limitations or directions provided
 117 for in the General Appropriations Act, these payments shall be
 118 made only for services included in the program, only on behalf
 119 of eligible individuals, and only to qualified providers in
 120 accordance with federal requirements for Title XIX of the Social
 121 Security Act and the provisions of state law. This program of
 122 medical assistance is designated as the "Medicaid program." The
 123 department is responsible for Medicaid eligibility
 124 determinations, including, but not limited to, policy, rules,
 125 and the agreement with the Social Security Administration for
 126 Medicaid eligibility determinations for Supplemental Security
 127 Income recipients, as well as the actual determination of
 128 eligibility. As a condition of Medicaid eligibility, subject to
 129 federal approval, the agency and the department shall ensure
 130 that each Medicaid recipient consents to the release of her or
 131 his medical records to the agency and the Medicaid Fraud Control
 132 Unit of the Department of Legal Affairs.

133 Section 5. Section 409.964, Florida Statutes is created to
 134 read:

135 409.964 Managed care program; state plan; waivers.—The
 136 Medicaid program is established as a statewide, integrated
 137 managed care program for all covered services, including long-
 138 term care services. The agency shall apply for and implement
 139 state plan amendments or waivers of applicable federal laws and

BILL

ORIGINAL

YEAR

140 regulations necessary to implement the program. Prior to seeking
 141 a waiver, the agency shall provide public notice and the
 142 opportunity for public comment and shall include public feedback
 143 in the waiver application. The agency shall hold one public
 144 meeting in each of the regions described in s. 409.966(2) and
 145 the time period for public comment for each region shall end no
 146 sooner than 30 days after the completion of the public meeting
 147 in that region.

148 Section 6. Section 409.965, Florida Statutes, is created
 149 to read:

150 409.965 Mandatory enrollment.—All Medicaid recipients
 151 shall receive covered services through the statewide managed
 152 care program, except as provided by this part pursuant to an
 153 approved federal waiver. The following Medicaid recipients are
 154 exempt from participation in the statewide managed care program:

155 (1) Women who are only eligible for family planning
 156 services.

157 (2) Women who are only eligible for breast and cervical
 158 cancer services.

159 (3) Persons who are eligible for emergency Medicaid for
 160 aliens.

161 Section 7. Section 409.966, Florida Statutes, is created
 162 to read:

163 409.966 Eligible plans; selection.—

164 (1) ELIGIBLE PLANS.—Services in the Medicaid managed care
 165 program shall be provided by eligible plans. A provider service
 166 network must be capable of providing all covered services to a
 167 mandatory Medicaid managed care enrollee or may limit the

BILL

ORIGINAL

YEAR

168 provision of services to a specific target population based on
 169 the age, chronic disease state, or the medical condition of the
 170 enrollee to whom the network will provide services. A specialty
 171 provider service network must be capable of coordinating care
 172 and delivering or arranging for the delivery of all covered
 173 services to the target population. A provider service network
 174 may partner with an insurer licensed under chapter 627 or a
 175 health maintenance organization licensed under chapter 641 to
 176 meet the requirements of a Medicaid contract.

177 (2) ELIGIBLE PLAN SELECTION.-The agency shall select a
 178 limited number of eligible plans to participate in the Medicaid
 179 program using invitations to negotiate in accordance with s.
 180 287.057(3) (a). At least 30 days prior to issuing an invitation
 181 to negotiate, the agency shall compile and publish a databook
 182 consisting of a comprehensive set of utilization and spending
 183 data for the 3 most recent contract years consistent with the
 184 rate-setting periods for all Medicaid recipients by region or
 185 county. The source of the data in the report shall include both
 186 historic fee-for-service claims and validated data from the
 187 Medicaid Encounter Data System. The report shall be made
 188 available in electronic form and shall delineate utilization use
 189 by age, gender, eligibility group, geographic area, and
 190 aggregate clinical risk score. Separate and simultaneous
 191 procurements shall be conducted in each of the following
 192 regions:

193 (a) Region I, which shall consist of Bay, Calhoun,
 194 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,

BILL ORIGINAL YEAR

195 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,
 196 Walton, and Washington Counties.

197 (b) Region II, which shall consist of Alachua, Baker,
 198 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,
 199 Gilchrist, Hamilton, Lafayette, Levy, Nassau, Putnam, St. Johns,
 200 Suwannee, Union, and Volusia Counties.

201 (c) Region III, which shall consist of Hernando,
 202 Hillsborough, Pasco, Pinellas, and Polk Counties.

203 (d) Region IV, which shall consist of Brevard, Indian
 204 River, Lake, Marion, Orange, Osceola, Seminole, and Sumter
 205 Counties.

206 (e) Region V, which shall consist of Charlotte, Collier,
 207 DeSoto, Hardee, Highlands, Lee, Manatee, and Sarasota Counties.

208 (f) Region VI, which shall consist of Broward, Glades,
 209 Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

210 (g) Region VII, which shall consist of Dade and Monroe
 211 Counties.

212 (3) QUALITY SELECTION CRITERIA.-

213 (a) The invitation to negotiate must specify the criteria
 214 and the relative weight of the criteria that will be used for
 215 determining the acceptability of the reply and guiding the
 216 selection of the organizations with which the agency negotiates.
 217 In addition to criteria established by the agency, the agency
 218 shall consider the following factors in the selection of
 219 eligible plans:

220 1. Accreditation by the National Committee for Quality
 221 Assurance or another nationally recognized accrediting body.

BILL

ORIGINAL

YEAR

222 2. Experience serving similar populations, including the
 223 organization's record in achieving specific quality standards
 224 with similar populations.

225 3. Availability and accessibility of primary care and
 226 specialty physicians in the provider network.

227 4. Establishment of community partnerships with providers
 228 that create opportunities for reinvestment in community-based
 229 services.

230 5. Organization commitment to quality improvement and
 231 documentation of achievements in specific quality improvement
 232 projects, including active involvement by organization
 233 leadership.

234 6. Provision of additional benefits, particularly dental
 235 care and disease management, and other initiatives that improve
 236 health outcomes.

237 7. Evidence that a qualified plan has written agreements
 238 or signed contracts or has made substantial progress in
 239 establishing relationships with providers prior to the plan
 240 submitting a response.

241 8. Comments submitted in writing by any enrolled Medicaid
 242 provider relating to a specifically identified plan
 243 participating in the procurement in the same region as the
 244 submitting provider. The agency shall give special weight to
 245 comments submitted by essential providers, as defined by the
 246 agency pursuant to s. 409.975(2).

247 (b) After negotiations are conducted, the agency shall
 248 select the eligible plans that are determined to be responsive

BILL

ORIGINAL

YEAR

249 and provide the best value to the state. Preference shall be
 250 given to plans which demonstrate the following:

251 1. Signed contracts with primary and specialty physicians
 252 in sufficient numbers to meet the specific standards established
 253 pursuant to s. 409.967(2) (b).

254 2. Well-defined programs for recognizing patient-centered
 255 medical homes or accountable care organizations, and providing
 256 for increased compensation for recognized medical homes or
 257 accountable care organizations, as defined by the plan.

258 3. Greater net economic benefit to Florida compared to
 259 other bidders through employment of, or subcontracting with
 260 firms which employ, Floridians in order to accomplish the
 261 contract requirements. Contracts with such bidders shall specify
 262 performance measures to evaluate the plan's employment-based
 263 economic impact. Valuation of the net economic benefit shall not
 264 include employment of or subcontracts with providers.

265 (c) To ensure managed care plan participation in Region I,
 266 the agency shall award contracts in Region VII to each managed
 267 care plan selected in Region I, for such plans which submitted
 268 responsive bids in Region VII.

269 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that
 270 participates in an invitation to negotiate in more than one
 271 region and is selected in at least one region may not begin
 272 serving Medicaid recipients in any region for which it was
 273 selected until all administrative challenges to procurements
 274 required by this section to which the eligible plan is a party
 275 have been finalized. If the number of plans selected is less
 276 than the maximum amount of plans permitted in the region, the

BILL

ORIGINAL

YEAR

277 agency may contract with other selected plans in the region not
 278 participating in the administrative challenge prior to
 279 resolution of the administrative challenge. For purposes of this
 280 subsection, an administrative challenge is finalized if an order
 281 granting voluntary dismissal with prejudice has been entered by
 282 any court established under Article V of the State Constitution
 283 or by the Division of Administrative Hearings, a final order has
 284 been entered into by the agency and the deadline for appeal has
 285 expired, a final order has been entered by the First District
 286 Court of Appeal and the time to seek any available review by the
 287 Florida Supreme Court has expired, or a final order has been
 288 entered by the Florida Supreme Court and a warrant has been
 289 issued.

290 Section 8. Section 409.967, Florida Statutes, is created
 291 to read:

292 409.967 Managed care plan accountability.-

293 (1) The agency shall establish a 5-year contract with each
 294 managed care plan selected through the procurement process
 295 described in s. 409.966. A plan contract may not be renewed;
 296 however, the agency may extend the terms of a plan contract to
 297 cover any delays in transition to a new plan.

298 (2) The agency shall establish such contract requirements
 299 as are necessary for the operation of the statewide managed care
 300 program. In addition to any other provisions the agency may deem
 301 necessary, the contract shall require:

302 (a) Emergency services.-Managed care plans shall pay for
 303 services required by ss. 395.1041 and 401.45 and rendered by a
 304 noncontracted provider within 30 days after receipt of a

BILL

ORIGINAL

YEAR

305 complete and correct claim. Plans must give providers of these
 306 services a specific explanation for each claim denied for being
 307 incomplete or incorrect. Providers shall have an opportunity to
 308 resubmit corrected claims for reconsideration within 30 days
 309 after receiving notice from the managed care plans of the claims
 310 being incomplete or incorrect. Payments for noncontracted
 311 emergency services and care shall be made at the rate the agency
 312 would pay for such services from the same provider. Claims from
 313 noncontracted providers shall be accepted by the managed care
 314 plan for at least 1 year after the date the services are
 315 provided.

316 (b) Access.—The agency shall establish specific standards
 317 for the number, type, and regional distribution of providers in
 318 managed care plan networks to ensure access to care. Each plan
 319 must maintain a region-wide network of providers in sufficient
 320 numbers to meet the access standards for specific medical
 321 services for all recipients enrolled in the plan. Each plan
 322 shall establish and maintain an accurate and complete electronic
 323 database of contracted providers, including information about
 324 licensure or registration, locations and hours of operation,
 325 specialty credentials and other certifications, specific
 326 performance indicators, and such other information as the agency
 327 deems necessary. The database shall be available online to both
 328 the agency and the public and shall have the capability to
 329 compare the availability of providers to network adequacy
 330 standards and to accept and display feedback from each
 331 provider's patients. Each plan shall submit quarterly reports to

BILL

ORIGINAL

YEAR

332 the agency identifying the number of enrollees assigned to each
 333 primary care provider.

334 (c) Encounter data.—The agency shall maintain and operate
 335 a Medicaid Encounter Data System to collect, process, store, and
 336 report on covered services provided to all Medicaid recipients
 337 enrolled in prepaid plans.

338 1. Each prepaid plan must comply with the agency's
 339 reporting requirements for the Medicaid Encounter Data System.
 340 Prepaid plans must submit encounter data electronically in a
 341 format that complies with the Health Insurance Portability and
 342 Accountability Act provisions for electronic claims and in
 343 accordance with deadlines established by the agency. Prepaid
 344 plans must certify that the data reported is accurate and
 345 complete.

346 2. The agency is responsible for validating the data
 347 submitted by the plans. The agency shall develop methods and
 348 protocols for ongoing analysis of the encounter data that
 349 adjusts for differences in characteristics of prepaid plan
 350 enrollees to allow comparison of service utilization among plans
 351 and against expected levels of use. The analysis shall be used
 352 to identify possible cases of systemic under-utilization or
 353 denials of claims and inappropriate service utilization such as
 354 higher-than-expected emergency department encounters. The
 355 analysis shall provide periodic feedback to the plans and enable
 356 the agency to establish corrective action plans when necessary.
 357 One of the focus areas for the analysis shall be the use of
 358 prescription drugs.

BILL

ORIGINAL

YEAR

359 3. The agency shall make encounter data available to those
 360 plans accepting enrollees who are assigned to them from other
 361 plans leaving a region.

362 (d) Continuous improvement.—The agency shall establish
 363 specific performance standards and expected milestones or
 364 timelines for improving performance over the term of the
 365 contract. Each managed care plan shall establish an internal
 366 health care quality improvement system, including enrollee
 367 satisfaction and disenrollment surveys. The quality improvement
 368 system shall include incentives and disincentives for network
 369 providers.

370 (e) Program integrity.—Each managed care plan shall
 371 establish program integrity functions and activities to reduce
 372 the incidence of fraud and abuse, including, at a minimum:

373 1. A provider credentialing system and ongoing provider
 374 monitoring;

375 2. An effective prepayment and post-payment review process
 376 including, but not limited to, data analysis, system editing,
 377 and auditing of network providers;

378 3. Procedures for reporting instances of fraud and abuse
 379 pursuant to chapter 641;

380 4. Administrative and management arrangements or
 381 procedures, including a mandatory compliance plan, designed to
 382 prevent fraud and abuse; and

383 5. Designation of a program integrity compliance officer.

384 (f) Grievance resolution.—Each managed care plan shall
 385 establish and the agency shall approve an internal process for
 386 reviewing and responding to grievances from enrollees consistent

BILL

ORIGINAL

YEAR

387 with the requirements of s. 641.511. Each plan shall submit
 388 quarterly reports on the number, description, and outcome of
 389 grievances filed by enrollees. The agency shall maintain a
 390 process for provider service networks consistent with s.
 391 408.7056.

392 (g) Penalties.—Managed care plans that reduce enrollment
 393 levels or leave a region prior to the end of the contract term
 394 shall reimburse the agency for the cost of enrollment changes
 395 and other transition activities, including the cost of
 396 additional choice counseling services. If more than one plan
 397 leaves a region at the same time, costs shall be shared by the
 398 departing plans proportionate to their enrollments. In addition
 399 to the payment of costs, departing plans shall pay a per
 400 enrollee penalty not to exceed 1 month's payment. Plans shall
 401 provide the agency notice no less than 180 days prior to
 402 withdrawing from a region.

403 (h) Prompt payment.—Managed care plans shall comply with
 404 ss. 641.315, 641.3155, and 641.513.

405 (i) Electronic claims.—Managed care plans shall accept
 406 electronic claims in compliance with federal standards.

407 (j) Fair Payment.—Provider service networks must ensure
 408 that no network provider with a controlling interest in the
 409 network charges any Medicaid managed care plan more than the
 410 amount paid to that provider by the provider service network for
 411 the same service.

412 (3) ACHIEVED SAVINGS REBATE.—

413 (a) The agency shall establish and the prepaid plans shall
 414 use a uniform method for annually reporting premium revenue,

BILL

ORIGINAL

YEAR

415 medical and administrative costs, and income or losses, across
 416 all Florida Medicaid prepaid plan lines of business. The
 417 reports shall be due to the agency no more than 270 days after
 418 the conclusion of the reporting period and the agency may audit
 419 the reports. Achieved savings rebates will be due within 30 days
 420 of the reports. Except as provided in paragraph (b), the
 421 achieved savings rebate will be established by determining pre-
 422 tax income as a percentage of revenues and applying the
 423 following income sharing ratios:

424 1. 100 percent of income up to and including 5 percent of
 425 revenue will be retained by the plan.

426 2. 50 percent of income above 5 percent and up to 9
 427 percent will be retained by the plan, with the other 50 percent
 428 refunded to the state.

429 3. 100 percent of income above 9 percent of revenue will
 430 be refunded to the state.

431 (b) For any plan which meets or exceeds agency-defined
 432 quality measures in the reporting period, the achieved savings
 433 rebate will be established by determining pre-tax income as a
 434 percentage of revenues and applying the following income sharing
 435 ratios:

436 1. 100 percent of income up to and including 6 percent of
 437 revenue will be retained by the plan.

438 2. 50 percent of income above 5 percent and up to 10
 439 percent will be retained by the plan, with the other 50 percent
 440 refunded to the state.

441 3. 100 percent of income above 10 percent of revenue will
 442 be refunded to the state.

BILL ORIGINAL YEAR

443 (c) The following shall not be included in calculating
 444 income to the plan:
 445 1. Payment of achieved savings rebates
 446 2. Any financial incentive payments made outside of the
 447 capitation rate
 448 3. Any financial disincentive payments levied by the
 449 state or federal governments
 450 4. Expenses associated with lobbying activities; and
 451 5. Administrative, reinsurance, and outstanding claims
 452 expenses in excess of actuarially sound maximum amounts set by
 453 the agency.

454 (d) Prepaid plans that incur a loss in the first contract
 455 year, may apply the full amount of the loss as an offset to
 456 income in the second contract year.

457 (e) If, after an audit or other reconciliation, the agency
 458 determines that a prepaid plan owes an additional rebate, the
 459 plan shall have 30 days after notification to make the payment.
 460 Upon failure to pay the rebate timely, the agency shall withhold
 461 future payments to the plan until the entire amount is recouped.
 462 If agency determines that a prepaid plan has made an
 463 overpayment, the agency shall return the overpayment within 30
 464 days.

465 Section 9. Section 409.968, Florida Statutes, is created
 466 to read:

467 409.968 Managed care plan payment.—

468 (1) Prepaid plans shall receive per-member, per-month
 469 payments negotiated pursuant to the procurements described in s.
 470 409.966. Payments shall be risk-adjusted rates based on

BILL

ORIGINAL

YEAR

471 historical utilization and spending data, projected forward, and
 472 adjusted to reflect the eligibility category, geographic area,
 473 and the clinical risk profile of the recipients.

474 (2) Provider service networks may be prepaid plans and
 475 receive per-member, per-month payments negotiated pursuant to
 476 the procurement process described in s. 409.966. Provider
 477 service networks that choose not to be prepaid plans shall
 478 receive fee-for-service rates with a shared savings settlement.
 479 The fee-for-service option shall be available to a provider
 480 service network only for the first 5 years of its operation in a
 481 given region or until the contract year that begins on October
 482 1, 2016, whichever is later. The agency shall annually conduct
 483 cost reconciliations to determine the amount of cost savings
 484 achieved by fee-for-service provider service networks for the
 485 dates of service within the period being reconciled. Only
 486 payments for covered services for dates of service within the
 487 reconciliation period and paid within 6 months after the last
 488 date of service in the reconciliation period shall be included.
 489 The agency shall perform the necessary adjustments for the
 490 inclusion of incurred but not reported claims within the
 491 reconciliation period for claims that could be received and paid
 492 by the agency after the 6-month claims processing time lag. The
 493 agency shall provide the results of the reconciliations to the
 494 fee-for-service provider service networks within 45 days after
 495 the end of the reconciliation period. The fee-for-service
 496 provider service networks shall review and provide written
 497 comments or a letter of concurrence to the agency within 45 days

BILL

ORIGINAL

YEAR

498 after receipt of the reconciliation results. This reconciliation
 499 shall be considered final.

500 Section 10. Section 409.969, Florida Statutes, is created
 501 to read:

502 409.969 Enrollment; choice counseling; automatic
 503 assignment; disenrollment.-

504 (1) ENROLLMENT.-All Medicaid recipients shall be enrolled
 505 in a managed care plan unless specifically exempted in this
 506 part. Each recipient shall have a choice of plans and may select
 507 any available plan unless that plan is restricted by contract to
 508 a specific population that does not include the recipient.
 509 Medicaid recipients shall have 30 days in which to make a choice
 510 of plans. All recipients shall be offered choice counseling
 511 services in accordance with this section.

512 (2) CHOICE COUNSELING.-The agency shall provide choice
 513 counseling for Medicaid recipients. The agency may contract for
 514 the provision of choice counseling. Any such contract shall be
 515 with a vendor which employs Floridians to accomplish the
 516 contract requirements and shall be for a period of 5 years. The
 517 agency may renew a contract for an additional 5-year period;
 518 however, prior to renewal of the contract the agency shall hold
 519 at least one public meeting in each of the regions covered by
 520 the choice counseling vendor. The agency may extend the term of
 521 the contract to cover any delays in transition to a new
 522 contractor. Printed choice information and choice counseling
 523 shall be offered in the native or preferred language of the
 524 recipient, consistent with federal requirements. The manner and
 525 method of choice counseling shall be modified as necessary to

BILL

ORIGINAL

YEAR

526 assure culturally competent, effective communication with people
 527 from diverse cultural backgrounds. The agency shall maintain a
 528 record of the recipients who receive such services, identifying
 529 the scope and method of the services provided. The agency shall
 530 make available clear and easily understandable choice
 531 information to Medicaid recipients that includes:

532 (a) An explanation that each recipient has the right to
 533 choose a managed care plan at the time of enrollment in Medicaid
 534 and again at regular intervals set by the agency, and that if a
 535 recipient does not choose a plan, the agency will assign the
 536 recipient to a plan according to the criteria specified in this
 537 section.

538 (b) A list and description of the benefits provided in
 539 each managed care plan.

540 (c) An explanation of benefit limits.

541 (d) A current list of providers participating in the
 542 network, including location and contact information.

543 (e) Managed care plan performance data.

544 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has
 545 enrolled in a managed care plan, the recipient shall have 90
 546 days to voluntarily disenroll and select another plan. After 90
 547 days, no further changes may be made except for good cause. Good
 548 cause includes, but is not limited to, poor quality of care,
 549 lack of access to necessary specialty services, an unreasonable
 550 delay or denial of service, or fraudulent enrollment. The agency
 551 must make a determination as to whether good cause exists. The
 552 agency may require a recipient to use the plan's grievance
 553 process prior to the agency's determination of good cause,

BILL

ORIGINAL

YEAR

554 except in cases in which immediate risk of permanent damage to
 555 the recipient's health is alleged.

556 (a) The managed care plan internal grievance process, when
 557 utilized, must be completed in time to permit the recipient to
 558 disenroll by the first day of the second month after the month
 559 the disenrollment request was made. If the result of the
 560 grievance process is approval of an enrollee's request to
 561 disenroll, the agency is not required to make a determination in
 562 the case.

563 (b) The agency must make a determination and take final
 564 action on a recipient's request so that disenrollment occurs no
 565 later than the first day of the second month after the month the
 566 request was made. If the agency fails to act within the
 567 specified timeframe, the recipient's request to disenroll is
 568 deemed to be approved as of the date agency action was required.
 569 Recipients who disagree with the agency's finding that good
 570 cause does not exist for disenrollment shall be advised of their
 571 right to pursue a Medicaid fair hearing to dispute the agency's
 572 finding.

573 (c) Medicaid recipients enrolled in a managed care plan
 574 after the 90-day period shall remain in the plan for the
 575 remainder of the 12-month period. After 12 months, the recipient
 576 may select another plan. However, nothing shall prevent a
 577 Medicaid recipient from changing providers within the plan
 578 during that period.

579 (d) On the first day of the next month after receiving
 580 notice from a recipient that the recipient has moved to another
 581 region, the agency shall automatically disenroll the recipient

BILL ORIGINAL YEAR

582 from the managed care plan the recipient is currently enrolled
 583 in and treat the recipient as if the recipient is a new Medicaid
 584 enrollee. At that time, the recipient may choose another plan
 585 pursuant to the enrollment process established in this section.

586 Section 11. Section 409.970, Florida Statutes, is created
 587 to read:

588 409.970 State and Local Medicaid Partnerships.-

589 (1) INTERGOVERNMENTAL TRANSFERS. In addition to the
 590 contributions required pursuant to s. 409.915, the agency may
 591 accept voluntary transfers of local taxes and other qualified
 592 revenue from counties, municipalities, and special taxing
 593 districts. Such transfers must be contributed to advance the
 594 general goals of the Florida Medicaid program without
 595 restriction and must be executed pursuant to a contract between
 596 the agency and the local funding source. Contracts executed
 597 prior to October 31 shall result in contributions to Medicaid
 598 for that same state fiscal year. Contracts executed between
 599 November 1 and June 30 shall result in contributions for the
 600 following state fiscal year. Based on the date of the signed
 601 contracts, the agency shall allocate to the Low Income Pool the
 602 first contributions received up to the limit established by
 603 subsection (2). No more than 40 percent of the Low Income Pool
 604 funding shall come from any single funding source.
 605 Contributions in excess of the Low Income Pool shall be
 606 allocated to the disproportionate share programs defined in s.
 607 409.911(3) and s. 409.9113, and to hospital rates pursuant to
 608 subsection (4). An attachment to the contract must designate
 609 the Medicaid providers that ensure access to care for low income

BILL ORIGINAL YEAR

610 and uninsured people within the applicable jurisdiction and
 611 which should be eligible for Low Income Pool funding. Eligible
 612 providers may include both hospitals and primary care providers.

613 (2) LOW INCOME POOL. The agency shall establish and
 614 maintain a Low Income Pool in a manner authorized by federal
 615 waiver. The Low Income Pool is created to compensate a network
 616 of providers designated pursuant to subsection (1). Funding of
 617 the Low Income Pool will be limited to the maximum amount
 618 permitted by federal waiver minus a percent specified in the
 619 General Appropriations Act. The Low Income Pool must be used to
 620 support enhanced access to services by offsetting shortfalls in
 621 Medicaid reimbursement, paying for otherwise uncompensated care,
 622 and financing coverage for the uninsured. The Low Income Pool
 623 shall be distributed in periodic payments to the Access to Care
 624 Partnership throughout the fiscal year. Distribution of Low
 625 Income Pool funds to providers participating in the Access to
 626 Care Partnership may be made through capitated payments, fees
 627 for services, or contracts for specific deliverables. The
 628 agency shall delineate the distributions from the Low Income
 629 Pool in the contract with the Access to Care Partnership
 630 pursuant to subsection (3). Regardless of the method of
 631 distribution, providers participating in the Access to Care
 632 Partnership shall receive payments such that the aggregate
 633 benefit in the jurisdiction of each local funding source, as
 634 defined in subsection (1), equals the amount of the contribution
 635 plus a factor specified in the General Appropriations Act.

636 (3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract
 637 with a single organization representing all health care

BILL ORIGINAL YEAR

638 facilities, programs, and providers supported with local taxes
 639 or certified public expenditures and designated pursuant to
 640 subsection (1). The contract shall provide for enhanced access
 641 to care for Medicaid, low-income, and uninsured Floridians. The
 642 partnership shall be responsible for an ongoing program of
 643 activities that provides needed, but uncovered or
 644 undercompensated, health services to Medicaid enrollees and
 645 persons receiving charity care, as defined in s. 409.911.
 646 Accountability for services rendered under this contract must be
 647 based on the number of unduplicated services provided to
 648 qualified beneficiaries, the total units of service provided to
 649 these persons, and the effectiveness of services provided as
 650 determined according to specific standards of care. The agency
 651 shall seek such plan amendments or waivers as may be necessary
 652 to authorize the implementation of the Low Income Pool as the
 653 Access to Care Partnership pursuant to this section.

654 (4) HOSPITAL RATE DISTRIBUTION.

655 (a) The agency is authorized to implement a tiered
 656 hospital rate system to enhance Medicaid payments to all
 657 hospitals when resources for the tiered rates are available from
 658 general revenue and such contributions pursuant to subsection
 659 (1) as are authorized by the General Appropriations Act.

660 1. Tier 1 hospitals are statutory rural hospitals as
 661 defined in s. 395.602, statutory teaching hospitals as defined
 662 in 408.07(45), and specialty children's hospitals as defined in
 663 s. 395.002(28).

664 2. Tier 2 hospitals are community hospitals not included
 665 in Tier 1 that provided more than 11 percent of the hospital's

BILL ORIGINAL YEAR

666 total inpatient days to Medicaid patients and are located in the
 667 jurisdiction of a local funding source pursuant to subsection
 668 (1).

669 3. Tier 3 hospitals include all community hospitals.

670 (b) When rates are increased pursuant to this section, the
 671 Total Tier Allocation (TTA) shall be allocated as follows:

672
 673 Tier 1 (T1A) = 0.50 x TTA;

674 Tier 2 (T2A) = 0.35 x TTA

675 Tier 3 (T3A) = 0.15 x TTA

676
 677 The Tier allocation will be distributed as a percent increase to
 678 the hospital specific base rate (HSBR) established pursuant to
 679 s. 409.905(5) (c). The increase in each tier will be calculated
 680 according to the proportion of tier-specific allocation to the
 681 total estimated inpatient spending (TEIS) for all hospitals in
 682 each tier:

683 Tier 1 percent increase (T1PI) = T1A/Tier 1 total estimated
 684 inpatient spending (T1TEIS);

685 Tier 2 percent increase (T2PI) = T2A / Tier 2 total
 686 estimated inpatient spending (T2TEIS);

687 Tier 3 percent increase (T3PI) = T3A/ Tier 3 total
 688 estimated inpatient spending (T3TEIS);

689
 690 The hospital specific tiered rate (HSTR) shall be calculated as
 691 follows:

692 For hospitals in Tier 3: HSTR = T3PI x HSBR

BILL ORIGINAL YEAR

693 For hospitals in Tier 2: HSTR = (T3PI x HSBR) + (T2PI x
 694 HSBR)

695 For hospitals in Tier 1: HSTR = (T3PI x HSBR) + (T2PI x
 696 HSBR) + (T1PI x HSBR)

697 Section 12. Section 409.971, Florida Statutes, is created
 698 to read:

699 409.971 Managed medical assistance program.—The agency
 700 shall make payments for primary and acute medical assistance and
 701 related services using a managed care model. By January 1, 2013,
 702 the agency shall begin implementation of the statewide managed
 703 medical assistance program, with full implementation in all
 704 regions by October 1, 2014.

705 Section 13. Section 409.972, Florida Statutes, is created
 706 to read:

707 409.972 Mandatory and voluntary enrollment.—

708 (1) Persons eligible for the program known as "medically
 709 needy" pursuant to s. 409.904(2) (a) shall enroll in managed care
 710 plans. Medically needy recipients shall meet the share of cost
 711 by paying the plan premium, up to the share of cost amount,
 712 contingent upon federal approval.

713 (2) The following Medicaid-eligible persons are exempt
 714 from mandatory managed care enrollment required by s. 409.965,
 715 and may voluntarily choose to participate in the managed medical
 716 assistance program:

717 (a) Medicaid recipients who have other creditable health
 718 care coverage, excluding Medicare.

BILL

ORIGINAL

YEAR

719 (b) Medicaid recipients residing in residential commitment
 720 facilities operated through the Department of Juvenile Justice,
 721 mental health treatment facilities as defined by s. 394.455(32).

722 (c) Persons eligible for refugee assistance.

723 (d) Medicaid recipients who are residents of a
 724 developmental disability center including Sunland Center in
 725 Marianna and Tacachale in Gainesville.

726 (3) Persons eligible for Medicaid but exempt from
 727 mandatory participation who do not choose to enroll in managed
 728 care shall be served in the Medicaid fee-for-service program as
 729 provided in part III of this chapter.

730 Section 14. Section 409.973, Florida Statutes, is created
 731 to read:

732 409.973 Benefits.—

733 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a
 734 minimum, the following services:

735 (a) Advanced registered nurse practitioner services.

736 (b) Ambulatory surgical treatment center services.

737 (c) Birthing center services.

738 (d) Chiropractic services.

739 (e) Dental services.

740 (f) Early periodic screening diagnosis and treatment
 741 services for recipients under age 21.

742 (g) Emergency services.

743 (h) Family planning services and supplies.

744 (i) Healthy start services.

745 (j) Hearing services.

746 (k) Home health agency services.

BILL

ORIGINAL

YEAR

- 747 | (l) Hospice services.
- 748 | (m) Hospital inpatient services.
- 749 | (n) Hospital outpatient services.
- 750 | (o) Laboratory and imaging services.
- 751 | (p) Medical supplies, equipment, prostheses, and orthoses.
- 752 | (q) Mental health services.
- 753 | (r) Nursing care.
- 754 | (s) Optical services and supplies.
- 755 | (t) Optometrist services.
- 756 | (u) Physical, occupational, respiratory, and speech
- 757 | therapy services.
- 758 | (v) Physician services.
- 759 | (w) Podiatric services.
- 760 | (x) Prescription drugs.
- 761 | (y) Renal dialysis services.
- 762 | (z) Respiratory equipment and supplies.
- 763 | (aa) Rural health clinic services.
- 764 | (bb) Substance abuse treatment services.
- 765 | (cc) Transportation to access covered services.
- 766 | (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
- 767 | benefit packages for nonpregnant adults, vary cost-sharing
- 768 | provisions, and provide coverage for additional services. The
- 769 | agency shall evaluate the proposed benefit packages to ensure
- 770 | services are sufficient to meet the needs of the plans'
- 771 | enrollees and to verify actuarial equivalence.
- 772 | (3) HEALTHY BEHAVIORS.—Each plan operating in the managed
- 773 | medical assistance program shall establish a program to
- 774 | encourage and reward healthy behaviors.

BILL

ORIGINAL

YEAR

775 Section 15. Section 409.974, Florida Statutes, is created
776 to read:

777 409.974 Eligible plans.-

778 (1) ELIGIBLE PLAN SELECTION.-The agency shall select
779 eligible plans through the procurement described in s. 409.966.
780 The agency shall notice invitations to negotiate no later than
781 January 1, 2013.

782 (a) The agency shall procure three plans for Region I. At
783 least one plan shall be a provider service network, if any
784 provider service network submits a responsive bid.

785 (b) The agency shall procure at least three and no more
786 than six plans for Region II. At least one plan shall be a
787 provider service network, if any provider service network
788 submits a responsive bid.

789 (c) The agency shall procure at least four plans and no
790 more than eight plans for Region III. At least two plans shall
791 be provider service networks, if any two provider service
792 networks submit responsive bids.

793 (d) The agency shall procure at least four plans and no
794 more than seven plans for Region IV. At least two plans shall be
795 provider service networks if any two provider service networks
796 submit responsive bids.

797 (e) The agency shall procure three plans for Region V. At
798 least one plan shall be a provider service network, if any
799 provider service network submits a responsive bid.

800 (f) The agency shall procure at least four plans and no
801 more than seven plans for Region VI. At least two plans shall be

BILL

ORIGINAL

YEAR

802 provider service networks, if any two provider service networks
 803 submit a responsive bid.

804 (g) The agency shall procure at least five plans and no
 805 more than nine plans for Region VII. At least two plans shall be
 806 provider service networks, if any two provider service network
 807 submit responsive bids.

808
 809 If no provider service network submits a responsive bid, the
 810 agency shall procure no more than one less than the maximum
 811 number of eligible plans permitted in that region. Within 12
 812 months after the initial invitation to negotiate, the agency
 813 shall attempt to procure a provider service network. The agency
 814 shall notice another invitation to negotiate only with provider
 815 service networks in such region where no provider service
 816 network has been selected.

817 (2) QUALITY SELECTION CRITERIA.-In addition to the
 818 criteria established in s. 409.966, the agency shall consider
 819 evidence that an eligible plan has written agreements or signed
 820 contracts or has made substantial progress in establishing
 821 relationships with providers prior to the plan submitting a
 822 response. The agency shall evaluate and give special weight to
 823 evidence of signed contracts with essential providers as defined
 824 by the agency pursuant to s. 409.975(2). When all other factors
 825 are equal, the agency shall consider whether the organization
 826 has a contract to provide managed long-term care services in the
 827 same region and shall exercise a preference for such plans.

828 (3) SPECIALTY PLANS.- Participation by specialty plans
 829 shall be subject to the procurement requirements and regional

BILL

ORIGINAL

YEAR

830 plan number limits of this section. However, a specialty plan
 831 whose target population includes no more than 10 percent of the
 832 enrollees of that region shall not be subject to the regional
 833 plan number limits of this section.

834 (4) CHILDREN'S MEDICAL SERVICES NETWORK.- Participation by
 835 the Children's Medical Services Network shall be pursuant to a
 836 single, statewide contract with the agency that is not subject
 837 to the procurement requirements or regional plan number limits
 838 of this section. The Children's Medical Services Network must
 839 meet all other plan requirements for the managed medical
 840 assistance program.

841 Section 16. Section 409.975, Florida Statutes, is created
 842 to read:

843 409.975 Managed care plan accountability.-In addition to
 844 the requirements of s. 409.967, plans and providers
 845 participating in the managed medical assistance program shall
 846 comply with the requirements of this section.

847 (1) PROVIDER NETWORKS.-Managed care plans must develop and
 848 maintain provider networks that meet the medical needs of their
 849 enrollees in accordance with standards established pursuant to
 850 409.967(2)(b). Except as provided in this section, managed care
 851 plans may limit the providers in their networks based on
 852 credentials, quality indicators, and price.

853 (a) Plans must include all providers in the region that
 854 are classified by the agency as essential Medicaid providers,
 855 unless the agency approves, in writing, an alternative
 856 arrangement for securing the types of services offered by the
 857 essential providers. Providers are essential for serving

BILL

ORIGINAL

YEAR

858 Medicaid enrollees if they offer services that are not available
 859 from any other provider within a reasonable access standard, or
 860 if they provided a substantial share of the total units of a
 861 particular service used by Medicaid patients within the region
 862 during the last three years and the combined capacity of other
 863 service providers in the region is insufficient to meet the
 864 total needs of the Medicaid patients. The agency may not
 865 classify physicians and other practitioners as essential
 866 providers. The agency, at a minimum, shall determine which
 867 providers in the following categories are essential Medicaid
 868 providers:

- 869 1. Federally qualified health centers;
- 870 2. Statutory teaching hospitals as defined in s.
 871 408.07(45);
- 872 3. Hospitals that are trauma centers as defined in s.
 873 395.4001(14);
- 874 4. Hospitals located at least 25 miles from any other
 875 hospital with similar services.

876

877 Managed care plans that have not contracted with all essential
 878 providers in the region as of the first date of recipient
 879 enrollment, or with whom an essential provider has terminated
 880 its contract, must negotiate in good faith with such essential
 881 providers for one year or until an agreement is reached,
 882 whichever is first. Payments for services rendered by a non-
 883 participating essential provider shall be made at the applicable
 884 Medicaid rate as of the first day of the contract between the
 885 agency and the plan. A rate schedule for all essential

BILL

ORIGINAL

YEAR

886 providers shall be attached to the contract between the agency
 887 and the plan. After one year, managed care plans that are unable
 888 to contract with essential providers shall notify the agency and
 889 propose an alternative arrangement for securing the essential
 890 services for Medicaid enrollees. The arrangement must rely on
 891 contracts with other participating providers, regardless of
 892 whether those providers are located within the same region as
 893 the non-participating essential service provider. If the
 894 alternative arrangement is approved by the agency, payments to
 895 non-participating essential providers after the date of the
 896 agency's approval shall equal 90 percent of the applicable
 897 Medicaid rate. If the alternative arrangement is not approved
 898 by the agency, payment to non-participating essential providers
 899 shall equal 110 percent of the applicable Medicaid rate.

900 (b) Certain providers are statewide resources and essential
 901 providers for all managed care plans in all regions. All
 902 managed care plans must include these essential providers in
 903 their networks. Statewide essential providers include:

- 904 1. Faculty plans of Florida medical schools;
- 905 2. Regional perinatal intensive care centers as defined in
 906 s. 383.16(2); and,
- 907 3. Hospitals licensed as specialty children's hospitals as
 908 defined in s. 395.002(28).

909
 910 Managed care plans that have not contracted with all statewide
 911 essential providers in all regions as of the first date of
 912 recipient enrollment must continue to negotiate in good faith.
 913 Payments to physicians on the faculty of non-participating

BILL

ORIGINAL

YEAR

914 Florida medical schools shall be made at the applicable Medicaid
 915 rate. Payments for services rendered by a regional perinatal
 916 intensive care centers shall be made at the applicable Medicaid
 917 rate as of the first day of the contract between the agency and
 918 the plan. Payments to non-participating specialty children's
 919 hospitals shall equal the highest rate established by contract
 920 between that provider and any other Medicaid managed care plan.

921 (c) After 12 months of active participation in a plan's
 922 network, the plan may exclude any essential provider from the
 923 network for failure to meet quality or performance criteria. If
 924 the plan excludes an essential provider from the plan, the plan
 925 must provide written notice to all recipients who have chosen
 926 that provider for care. The notice shall be provided at least 30
 927 days prior to the effective date of the exclusion.

928 (d) Each managed care plan must offer a network contract
 929 to each home medical equipment and supplies provider in the
 930 region which meets quality and fraud prevention and detection
 931 standards established by the plan, and which agrees to accept
 932 the lowest price previously negotiated between the plan and
 933 another such provider.

934 (2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency
 935 shall contract with a single organization representing medical
 936 schools and graduate medical education programs in Florida for
 937 the purpose of establishing an active and ongoing program to
 938 improve clinical outcomes in all managed care plans. Contracted
 939 activities must support greater clinical integration for
 940 Medicaid enrollees through interdependent and cooperative
 941 efforts of all providers participating in managed care plans.

BILL ORIGINAL YEAR

942 The agency shall support these activities with certified public
 943 expenditures of general revenue appropriated to the
 944 participating medical schools and any earned federal matching
 945 funds, and shall seek any plan amendments or waivers necessary
 946 to comply with this subsection. To be eligible to participate in
 947 the quality network, a medical school must contract with each
 948 managed care plan in its region.

949 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
 950 monitor the quality and performance of each participating
 951 provider. At the beginning of the contract period, each plan
 952 shall notify all its network providers of the metrics used by
 953 the plan for evaluating the provider's performance and
 954 determining continued participation in the network.

955 (4) MOMCARE NETWORK.—

956 (a) The agency shall contract with an administrative
 957 services organization representing all Healthy Start Coalitions
 958 providing risk appropriate care coordination and other services
 959 in accordance with a federal waiver and pursuant to s. 409.906.
 960 The contract shall require the network of coalitions to provide
 961 choice counseling, education, risk-reduction and case management
 962 services, and quality assurance for all enrollees of the waiver.
 963 The agency shall evaluate the impact of the MomCare network by
 964 monitoring each plan's performance on specific measures to
 965 determine the adequacy, timeliness, and quality of services for
 966 pregnant women and infants. The agency shall support this
 967 contract with certified public expenditures of general revenue
 968 appropriated for Healthy Start services and any earned federal
 969 matching funds.

BILL

ORIGINAL

YEAR

970 (b) Each managed care plan shall establish specific
 971 programs and procedures to improve pregnancy outcomes and infant
 972 health, including, but not limited to, coordination with the
 973 Healthy Start program, immunization programs, and referral to
 974 the Special Supplemental Nutrition Program for Women, Infants,
 975 and Children, and the Children's Medical Services program for
 976 children with special health care needs. Each plan's programs
 977 and procedures shall include agreements with each local Healthy
 978 Start Coalition in the region to provide risk-appropriate care
 979 coordination for pregnant women and infants, consistent with the
 980 agency and the MomCare Network.

981 (5) TRANSPORTATION.-Non-emergency transportation services
 982 shall be provided pursuant to a single, statewide contract
 983 between the agency and the Commission for Transportation
 984 Disadvantaged. The agency shall establish performance standards
 985 in the contract and shall evaluate the performance of the
 986 Commission for Transportation Disadvantaged.

987 (6) SCREENING RATE.-After the end of the second contract
 988 year, each managed care plan shall achieve an annual Early and
 989 Periodic Screening, Diagnosis, and Treatment Service screening
 990 rate of at least 80 percent of those recipients continuously
 991 enrolled for at least 8 months.

992 (7) PROVIDER PAYMENT.-Managed care plan and hospitals
 993 shall negotiate mutually acceptable rates, methods, and terms of
 994 payment. At a minimum, plans shall pay hospitals the Medicaid
 995 rate. Payments to hospitals shall not exceed 120 percent of the
 996 rate the agency would have paid on the first day of the contract

BILL

ORIGINAL

YEAR

997 between the provider and the plan, unless specifically approved
 998 by the agency. Payment rates may be updated periodically.

999 (8) MEDICALLY NEEDED ENROLLEES.—Each managed care plan
 1000 shall accept any medically needy recipient who selects or is
 1001 assigned to the plan and provide that recipient with continuous
 1002 enrollment for 12 months. After the first month of qualifying as
 1003 a medically needy recipient and enrolling in a plan, and
 1004 contingent upon federal approval, the enrollee shall pay the
 1005 plan a portion of the monthly premium equal to the enrollee's
 1006 share of the cost as determined by the department. The agency
 1007 shall pay the remainder of the monthly premium. Plans must
 1008 provide a grace period of at least 90 days before disenrolling
 1009 recipients who fail to pay their shares of the premium.

1010 Section 17. Section 409.976, Florida Statutes, is created
 1011 to read:

1012 409.976 Managed care plan payment.—In addition to the
 1013 payment provisions of s. 409.968, the agency shall provide
 1014 payment to plans in the managed medical assistance program
 1015 pursuant to this section.

1016 (1) Prepaid payment rates shall be negotiated between the
 1017 agency and the eligible plans as part of the procurement
 1018 described in s. 409.966.

1019 (2) The agency shall establish payment rates for statewide
 1020 inpatient psychiatric programs. Payments to managed care plans
 1021 shall be reconciled to reimburse actual payments to statewide
 1022 inpatient psychiatric programs.

1023 Section 18. Section 409.977, Florida Statutes, is created
 1024 to read:

BILL

ORIGINAL

YEAR

1025 409.977 Choice counseling and enrollment.-
 1026 (1) CHOICE COUNSELING.-In addition to the choice
 1027 counseling information required by s. 409.969, the agency shall
 1028 make available clear and easily understandable choice
 1029 information to Medicaid recipients that includes information
 1030 about cost sharing requirements of each managed care plan.
 1031 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically
 1032 enroll into a managed care plan those Medicaid recipients who do
 1033 not voluntarily choose a plan pursuant to s. 409.969. The agency
 1034 shall automatically enroll recipients in plans that meet or
 1035 exceed the performance or quality standards established pursuant
 1036 to s. 409.967, and shall not automatically enroll recipients in
 1037 a plan that is deficient in those performance or quality
 1038 standards. When a specialty plan is available to accommodate a
 1039 specific condition or diagnosis of a recipient, the agency shall
 1040 assign the recipient to that plan. The agency may not engage in
 1041 practices that are designed to favor one managed care plan over
 1042 another. When automatically enrolling recipients in managed care
 1043 plans, the agency shall automatically enroll based on the
 1044 following criteria:
 1045 (a) Whether the plan has sufficient network capacity to
 1046 meet the needs of the recipients.
 1047 (b) Whether the recipient has previously received services
 1048 from one of the plan's primary care providers.
 1049 (c) Whether primary care providers in one plan are more
 1050 geographically accessible to the recipient's residence than
 1051 those in other plans.

BILL

ORIGINAL

YEAR

1052 (3) OPT-OUT OPTION.-The agency shall develop a process to
 1053 enable any recipient with access to employer-sponsored health
 1054 care coverage to opt out of all managed care plans and to use
 1055 Medicaid financial assistance to pay for the recipient's share
 1056 of the cost in such employer-sponsored coverage. Contingent upon
 1057 federal approval, the agency shall also enable recipients with
 1058 access to other insurance or related products providing access
 1059 to health care services created pursuant to state law, including
 1060 any product available under the Florida Health Choices Program,
 1061 or any health exchange, to opt out. The amount of financial
 1062 assistance provided for each recipient may not exceed the amount
 1063 of the Medicaid premium that would have been paid to a managed
 1064 care plan for that recipient.

1065 Section 19. Section 409.978, Florida Statutes, is created
 1066 to read:

1067 409.978 Long-term care managed care program.-

1068 (1) Pursuant to s. 409.963, the agency shall administer
 1069 the long-term care managed care program described in ss.
 1070 409.978-409.985, but may delegate specific duties and
 1071 responsibilities for the program to the Department of Elderly
 1072 Affairs and other state agencies. By July 1, 2012, the agency
 1073 shall begin implementation of the statewide long-term care
 1074 managed care program, with full implementation in all regions by
 1075 October 1, 2013.

1076 (2) The agency shall make payments for long-term care,
 1077 including home and community-based services, using a managed
 1078 care model. Unless otherwise specified, the provisions of ss.
 1079 409.961-409.970 apply to the long-term care managed care

BILL ORIGINAL YEAR

1080 program.

1081 (3) The Department of Elderly Affairs shall assist the
 1082 agency to develop specifications for use in the invitation to
 1083 negotiate and the model contract; determine clinical eligibility
 1084 for enrollment in managed long-term care plans; monitor plan
 1085 performance and measure quality of service delivery; assist
 1086 clients and families to address complaints with the plans;
 1087 facilitate working relationships between plans and providers
 1088 serving elders and disabled adults; and perform other functions
 1089 specified in a memorandum of agreement.

1090 Section 20. Section 409.979, Florida Statutes, is created
 1091 to read:

1092 409.979 Eligibility.-

1093 (1) Medicaid recipients who meet all of the following
 1094 criteria are eligible to receive long term care services and
 1095 must receive long term care services by participation in the
 1096 long-term care managed care program. The recipient must be:

1097 (a) Sixty-five years of age or older or eligible for
 1098 Medicaid by reason of a disability.

1099 (b) Determined by the Comprehensive Assessment Review and
 1100 Evaluation for Long-Term Care Services (CARES) Program to
 1101 require nursing facility care as defined in s. 409.985(3).

1102 (2) Medicaid recipients who, on the date long-term care
 1103 managed care plans become available in their region, reside in a
 1104 nursing home facility or are enrolled in one of the following
 1105 long-term care Medicaid waiver programs are eligible to
 1106 participate in the long-term care managed care program for up to
 1107 24 months without being re-evaluated for their need of nursing

BILL

ORIGINAL

YEAR

1108 facility care as defined in s. 409.985(3):
 1109 (a) The Assisted Living for the Frail Elderly Waiver.
 1110 (b) The Aged and Disabled Adult Waiver.
 1111 (c) The Adult Day Health Care Waiver.
 1112 (d) The Consumer-Directed Care Plus Program as described
 1113 in s. 409.221.
 1114 (e) The Program of All-inclusive Care for the Elderly.
 1115 (f) The Long-Term Care Community-Based Diversion Pilot
 1116 Project as described in s. 430.705.
 1117 (g) The Channeling Services Waiver for Frail Elders.
 1118 Section 21. Section 409.980, Florida Statutes, is created
 1119 to read:
 1120 409.980 Benefits.—Long term care plans shall cover, at a
 1121 minimum, the following:
 1122 (1) Nursing facility care.
 1123 (2) Services provided in assisted living facilities.
 1124 (3) Hospice.
 1125 (4) Adult day care.
 1126 (5) Medical equipment and supplies, including incontinence
 1127 supplies.
 1128 (5) Personal care.
 1129 (7) Home accessibility adaptation.
 1130 (9) Behavior management.
 1131 (9) Home delivered meals.
 1132 (10) Case management.
 1133 (11) Therapies:
 1134 (a) Occupational therapy
 1135 (b) Speech therapy

BILL ORIGINAL YEAR

- 1136 (c) Respiratory therapy
- 1137 (d) Physical therapy.
- 1138 (12) Intermittent and skilled nursing.
- 1139 (13) Medication administration.
- 1140 (14) Medication management.
- 1141 (15) Nutritional assessment and risk reduction.
- 1142 (16) Caregiver training.
- 1143 (17) Respite care.
- 1144 (18) Transportation.
- 1145 (19) Personal emergency response system.
- 1146 Section 22. Section 409.981, Florida Statutes, is created
- 1147 to read:
- 1148 409.981 Eligible plans.—
- 1149 (1) ELIGIBLE PLANS.— Provider service networks must be
- 1150 long-term care provider service networks. Other eligible plans
- 1151 may either be long-term care plans, or comprehensive long-term
- 1152 care plans.
- 1153 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
- 1154 eligible plans through the procurement described in s. 409.966.
- 1155 The agency shall notice invitations to negotiate no later than
- 1156 July 1, 2012.
- 1157 (a) The agency shall procure three plans for Region I. At
- 1158 least one plan shall be a provider service network, if any
- 1159 submit a responsive bid.
- 1160 (b) The agency shall procure at least three and no more
- 1161 than six plans for Region II. At least one plan shall be a
- 1162 provider service network, if any submit a responsive bid.

BILL

ORIGINAL

YEAR

1163 (c) The agency shall procure at least four plans and no
 1164 more than eight plans for Region III. At least two plans shall
 1165 be provider service networks, if any two submit responsive bids.

1166 (d) The agency shall procure at least four plans and no
 1167 more than seven plans for Region IV. At least two plans shall be
 1168 provider service networks, if any two submit responsive bids.

1169 (e) The agency shall procure three plans for Region V. At
 1170 least one plan shall be a provider service network, if any
 1171 submit a responsive bid.

1172 (f) The agency shall procure at least four plans and no
 1173 more than seven plans for Region VI. At least two plans shall be
 1174 provider service networks, if any two submit a responsive bid.

1175 (g) The agency shall procure at least five plans and no
 1176 more than nine plans for Region VII. At least two plans shall be
 1177 provider service networks, if any two submit responsive bids.

1178
 1179 If no provider service network submits a responsive bid, the
 1180 agency shall procure one fewer eligible plan in each of the
 1181 regions. Within 12 months after the initial invitation to
 1182 negotiate, the agency shall attempt to procure an eligible plan
 1183 that is a provider service network. The agency shall notice
 1184 another invitation to negotiate only with provider service
 1185 networks in such region where no provider service network has
 1186 been selected.

1187 (3) QUALITY SELECTION CRITERIA.—In addition to the criteria
 1188 established in s. 409.966, the agency shall consider the
 1189 following factors in the selection of eligible plans:

BILL

ORIGINAL

YEAR

1190 (a) Evidence of the employment of executive managers with
 1191 expertise and experience in serving aged and disabled persons
 1192 who require long-term care.

1193 (b) Whether a plan has established a network of service
 1194 providers dispersed throughout the region and in sufficient
 1195 numbers to meet specific service standards established by the
 1196 agency for specialty services for persons receiving home and
 1197 community-based care.

1198 (c) Whether a plan is proposing to establish a
 1199 comprehensive long-term care plan and whether the eligible plan
 1200 has a contract to provide managed medical assistance services in
 1201 the same region.

1202 (d) Whether a plan offers consumer-directed care services
 1203 to enrollees pursuant to s. 409.221.

1204 (e) Whether a plan is proposing to provide home and
 1205 community based services in addition to the minimum benefits
 1206 required by s. 409.980.

1207 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.-
 1208 Participation by the Program for All-Inclusive Care for the
 1209 Elderly (PACE) shall be pursuant to a contract with the agency
 1210 and not subject to the procurement requirements or regional plan
 1211 number limits of this section. PACE plans may continue to
 1212 provide services to individuals at such levels and enrollment
 1213 caps as authorized by the General Appropriations Act.

1214 Section 23. Section 409.982, Florida Statutes, is created
 1215 to read:

1216 409.982 Managed care plan accountability.-In addition to
 1217 the requirements of s. 409.967, plans and providers

BILL

ORIGINAL

YEAR

1218 participating in the long-term care managed care program shall
 1219 comply with the requirements of this section.

1221 (1) PROVIDER NETWORKS.—Managed care plans may limit the
 1222 providers in their networks based on credentials, quality
 1223 indicators, and price. For the period between October 1, 2013-
 1224 September 30, 2014, each selected plan must offer a network
 1225 contract to all the following providers in the region:

1226 (a) Nursing homes.

1227 (b) Hospices.

1228 (c) Aging network service providers that have previously
 1229 participated in home and community-based waivers serving elders
 1230 or community-service programs administered by the Department of
 1231 Elderly Affairs.

1232
 1233 After 12 months of active participation in a managed care plan's
 1234 network, the plan may exclude any of the providers named in this
 1235 subsection from the network for failure to meet quality or
 1236 performance criteria. If the plan excludes a provider from the
 1237 plan, the plan must provide written notice to all recipients who
 1238 have chosen that provider for care. The notice shall be provided
 1239 at least 30 days prior to the effective date of the exclusion.
 1240 The agency shall establish contract provisions governing the
 1241 transfer of recipients from excluded residential providers.

1242 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1243 this subsection, providers may limit the managed care plans they
 1244 join. Nursing homes and hospices which are enrolled Medicaid
 1245 providers must participate in all eligible plans selected by the

BILL

ORIGINAL

YEAR

1246 agency in the region in which the provider is located.
 1247 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
 1248 monitor the quality and performance of each participating
 1249 provider using measures adopted by and collected by the agency
 1250 and any additional measures mutually agreed upon by the provider
 1251 and the plan
 1252 (4) PROVIDER NETWORK STANDARDS.—The agency shall establish
 1253 and each managed care plan must comply with specific standards
 1254 for the number, type, and regional distribution of providers in
 1255 the plan's network, which must include:
 1256 (a) Adult day centers.
 1257 (b) Adult family care homes.
 1258 (c) Assisted living facilities.
 1259 (d) Health care services pools.
 1260 (e) Home health agencies.
 1261 (f) Homemaker and companion services.
 1262 (g) Hospices.
 1263 (h) Community Care for the Elderly Lead Agencies.
 1264 (i) Nurse registries.
 1265 (j) Nursing homes.
 1266 (5) PROVIDER PAYMENT.—Managed care plans and providers
 1267 shall negotiate mutually acceptable rates, methods, and terms of
 1268 payment. Plans shall pay nursing homes an amount equal to the
 1269 nursing facility-specific payment rates set by the agency;
 1270 however, mutually acceptable higher rates may be negotiated for
 1271 medically complex care. Plans shall pay hospice providers an
 1272 amount equal to the per diem rate set by the agency. For
 1273 recipients residing in a nursing facility and receiving hospice

BILL

ORIGINAL

YEAR

1274 services, the plan shall pay the hospice provider the per diem
 1275 rate set by the agency minus the nursing facility component and
 1276 shall pay the nursing facility the applicable state rate.

1277 Section 24. Section 409.983, Florida Statutes, is created
 1278 to read:

1279 409.983 Managed care plan payment.—In addition to the
 1280 payment provisions of s. 409.968, the agency shall provide
 1281 payment to plans in the long-term care managed care program
 1282 pursuant to this section.

1283 (1) Prepaid payment rates for long-term care managed care
 1284 plans shall be negotiated between the agency and the eligible
 1285 plans as part of the procurement described in s. 409.966.

1286 (2) Payment rates for comprehensive long-term care plans
 1287 covering services described in s. 409.973 shall be blended with
 1288 rates for long-term care plans for services specified in s.
 1289 409.980.

1290 (3) Payment rates for plans shall reflect historic
 1291 utilization and spending for covered services projected forward
 1292 and adjusted to reflect the level of care profile for enrollees
 1293 of each plan. The payment shall be adjusted to provide an
 1294 incentive for reducing institutional placements and increasing
 1295 the utilization of home and community-based services.

1296 (4) The initial assessment of an enrollee's level of care
 1297 shall be made by the Comprehensive Assessment and Review for
 1298 Long-Term-Care Services (CARES) program, which shall assign the
 1299 recipient into one of the following levels of care:

1300 (a) Level of care 1 consists of recipients residing in or
 1301 who must be placed in a nursing home.

BILL

ORIGINAL

YEAR

1302 (b) Level of care 2 consists of recipients at imminent
 1303 risk of nursing home placement as evidenced by the need for the
 1304 constant availability of routine medical and nursing treatment
 1305 and care, and require extensive health-related care and services
 1306 because of mental or physical incapacitation.

1307 (c) Level of care 3 consists of recipients at imminent
 1308 risk of nursing home placement as evidenced by the need for the
 1309 constant availability of routine medical and nursing treatment
 1310 and care, have a limited need for health-related care and
 1311 services, are mildly medically or physically incapacitated

1312
 1313 The agency shall periodically adjust payment rates to account
 1314 for changes in the level of care profile for each managed care
 1315 plan based on encounter data.

1316 (5) The agency shall make an incentive adjustment in
 1317 payment rates to encourage the increased utilization of home and
 1318 community based services and a commensurate reduction of
 1319 institutional placement. The incentive adjustment shall be
 1320 modified in each successive rate period during the first
 1321 contract period, as follows:

1322 (a) a 2 percentage point shift in the first rate setting
 1323 period;

1324 (b) a 2 percentage point shift in the second rate setting
 1325 period, as compared to the utilization mix at the end of the
 1326 first rate setting period;

1327 (c) a 3 percentage point shift in the third rate setting
 1328 period, and in each subsequent rate setting period during the
 1329 first contract period, as compared to the utilization mix at the

BILL ORIGINAL YEAR

1330 end of the immediately preceding rate setting period.

1331
 1332 The incentive adjustment shall continue in subsequent contract
 1333 periods, at a rate of 3 percentage points per year as compared
 1334 to the utilization mix at the end of the immediately preceding
 1335 rate setting period, until no more than 35 percent of the plan's
 1336 enrollees are placed in institutional settings. The agency shall
 1337 annually report to the Legislature the actual change in the
 1338 utilization mix of home and community based services compared to
 1339 institutional placements and provide a recommendation for
 1340 utilization mix requirements for future contracts.

1341 (6) The agency shall establish nursing facility-specific
 1342 payment rates for each licensed nursing home based on facility
 1343 costs adjusted for inflation and other factors as authorized in
 1344 the General Appropriations Act. Payments to long-term care
 1345 managed care plans shall be reconciled to reimburse actual
 1346 payments to nursing facilities.

1347 (7) The agency shall establish hospice payment rates.
 1348 Payments to long-term care managed care plans shall be
 1349 reconciled to reimburse actual payments to hospices.

1350 Section 25. Section 409.984, Florida Statutes, is created
 1351 to read:

1352 409.984 Choice counseling; enrollment.—

1353 (1) CHOICE COUNSELING.—Before contracting with a vendor to
 1354 provide choice counseling as authorized under s. 409.969, the
 1355 agency shall offer to contract with aging resource centers
 1356 established under s. 430.2053 for choice counseling services. If
 1357 the aging resource center is determined not to be the vendor

BILL

ORIGINAL

YEAR

1358 that provides choice counseling, the agency shall establish a
 1359 memorandum of understanding with the aging resource center to
 1360 coordinate staffing and collaborate with the choice counseling
 1361 vendor. In addition to the requirements of s. 409.969, any
 1362 contract to provide choice counseling for the long-term care
 1363 managed care program shall provide that each recipient be given
 1364 the option of having in-person choice counseling.

1365 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
 1366 enroll into a long-term care managed care plan those Medicaid
 1367 recipients who do not voluntarily choose a plan pursuant to s.
 1368 409.969. The agency shall automatically enroll recipients in
 1369 plans that meet or exceed the performance or quality standards
 1370 established pursuant to s. 409.967, and shall not automatically
 1371 enroll recipients in a plan that is deficient in those
 1372 performance or quality standards. If a recipient is deemed
 1373 dually eligible for Medicaid and Medicare services and is
 1374 currently receiving Medicare services from an entity qualified
 1375 under 42 C.F.R. part 422 as a Medicare Advantage Preferred
 1376 Provider Organization, Medicare Advantage Provider-sponsored
 1377 Organization, or Medicare Advantage Special Needs Plan, then the
 1378 agency shall automatically enroll the recipient in such plan for
 1379 Medicaid services if the plan is currently participating in the
 1380 long-term care managed care program. Except as provided by this
 1381 chapter, the agency may not engage in practices that are
 1382 designed to favor one managed care plan over another. When
 1383 automatically enrolling recipients in plans, the agency shall
 1384 take into account the following criteria:

BILL ORIGINAL YEAR

1385 (a) Whether the plan has sufficient network capacity to
 1386 meet the needs of the recipients.

1387 (b) Whether the recipient has previously received services
 1388 from one of the plan's home and community-based service
 1389 providers.

1390 (c) Whether the home and community-based providers in one
 1391 plan are more geographically accessible to the recipient's
 1392 residence than those in other plans.

1393 (3) HOSPICE SELECTION -- Notwithstanding the provisions of
 1394 s. 409.969(3)(c), when a recipient is referred for hospice
 1395 services, the recipient shall have a 30-day period during which
 1396 the recipient may select to enroll in another managed care plan
 1397 to access the hospice provider of the recipient's choice.

1398 (4) CHOICE of RESIDENTIAL SETTING - When a recipient is
 1399 referred for placement in a nursing home or assisted living
 1400 facility, the plan shall inform the recipient of any facilities
 1401 within the plan that have specific cultural or religious
 1402 affiliations and, if requested by the recipient, make a
 1403 reasonable effort to place the recipient in the facility of the
 1404 recipient's choice.

1405 Section 26. Section 409.9841. Florida Statutes is created
 1406 to read:

1407 409.9841 Long-term care managed care technical advisory
 1408 workgroup.--

1409 (1) Before August 1, 2011, the agency shall establish a
 1410 technical advisory workgroup to assist in developing:

1411 (a) the method of determining Medicaid eligibility
 1412 pursuant to s. 409.985(3).

BILL ORIGINAL YEAR

1413 (b) the requirements for provider payments to nursing
 1414 homes under s. 409.982(6).

1415 (c) the requirements for prompt payments by plans to
 1416 providers.

1417 (d) uniform requirements for claims submissions and
 1418 payments, including electronic funds transfers and claims
 1419 processing.

1420 (e) the process for enrollment of and payment for
 1421 individuals pending determination of Medicaid eligibility.

1422 (2) The advisory workgroup must include, but is not
 1423 limited to, representatives of providers and plans who could
 1424 potentially participate in long-term care managed care. Members
 1425 of the workgroup shall serve without compensation but are may be
 1426 reimbursed for per diem and travel expenses as provided in s.
 1427 112.061.

1428 (3) This section is repealed on June 30, 2013.

1429 Section 27. Section 409.985, Florida Statutes, is created
 1430 to read:

1431 409.985 Comprehensive Assessment and Review for Long-Term
 1432 Care Services (CARES) Program.—

1433 (1) The agency shall operate the Comprehensive Assessment
 1434 and Review for Long-Term Care Services (CARES) preadmission
 1435 screening program to ensure that only individuals whose
 1436 conditions require long-term care services are enrolled in the
 1437 long-term care managed care program.

1438 (2) The agency shall operate the CARES program through an
 1439 interagency agreement with the Department of Elderly Affairs.
 1440 The agency, in consultation with the Department of Elderly

BILL

ORIGINAL

YEAR

1441 Affairs, may contract for any function or activity of the CARES
 1442 program, including any function or activity required by 42
 1443 C.F.R. part 483.20, relating to preadmission screening and
 1444 review.

1445 (3) The CARES program shall determine if an individual
 1446 requires nursing facility care and, if the individual requires
 1447 such care, assign the individual to a level of care as described
 1448 in s. 409.983(4). When determining the need for nursing facility
 1449 care, consideration shall be given to the nature of the services
 1450 prescribed and which level of nursing or other health care
 1451 personnel meets the qualifications necessary to provide such
 1452 services and the availability to and access by the individual of
 1453 community or alternative resources. For the purposes of the
 1454 long-term care managed care program, "nursing facility care"
 1455 means the individual:

1456 (a) Requires nursing home placement as evidenced by the
 1457 need for medical observation throughout a 24 hour period and
 1458 care required to be performed on a daily basis by, or under the
 1459 direct supervision of, a registered nurse or other health care
 1460 professionals and requires services that are sufficiently
 1461 medically complex to require supervision, assessment, planning,
 1462 or intervention by a registered nurse because of mental or
 1463 physical incapacitation by the individual; or

1464 (b) Requires or is at imminent risk of nursing home
 1465 placement as evidenced by the need for observation throughout a
 1466 24 hour period and care and the constant availability of medical
 1467 and nursing treatment and requires services on a daily or
 1468 intermittent basis that are to be performed under the

BILL

ORIGINAL

YEAR

1469 supervision of licensed nursing or other health professionals
 1470 because the individual who is incapacitated mentally or
 1471 physically; or

1472 (c) Requires or is at imminent risk of nursing home
 1473 placement as evidenced by the need for observation throughout a
 1474 24 hour period and care and the constant availability of medical
 1475 and nursing treatment and requires limited services that are to
 1476 be performed under the supervision of licensed nursing or other
 1477 health professionals because the individual who is mildly
 1478 incapacitated mentally or physically.

1479 (4) For individuals whose nursing home stay is initially
 1480 funded by Medicare and Medicare coverage is being terminated for
 1481 lack of progress towards rehabilitation, CARES staff shall
 1482 consult with the person making the determination of progress
 1483 toward rehabilitation to ensure that the recipient is not being
 1484 inappropriately disqualified from Medicare coverage. If, in
 1485 their professional judgment, CARES staff believes that a
 1486 Medicare beneficiary is still making progress toward
 1487 rehabilitation, they may assist the Medicare beneficiary with an
 1488 appeal of the disqualification from Medicare coverage. The use
 1489 of CARES teams to review Medicare denials for coverage under
 1490 this section is authorized only if it is determined that such
 1491 reviews qualify for federal matching funds through Medicaid. The
 1492 agency shall seek or amend federal waivers as necessary to
 1493 implement this section.

1494 Section 28. Section 409.986, Florida Statutes, is created
 1495 to read:

BILL

ORIGINAL

YEAR

1496 409.986 Managed long-term care for persons with
 1497 developmental disabilities.-
 1498 (1) Pursuant to s. 409.963, the agency is responsible for
 1499 administering the long-term care managed care program for
 1500 persons with developmental disabilities described in ss.
 1501 409.986-409.992, but may delegate specific duties and
 1502 responsibilities for the program to the Agency for Persons with
 1503 Disabilities and other state agencies. By January 1,2015, the
 1504 agency shall begin implementation of statewide long-term care
 1505 managed care for persons with developmental disabilities, with
 1506 full implementation in all regions by October 1, 2016.
 1507 (2) The agency shall make payments for long-term care for
 1508 persons with developmental disabilities, including home and
 1509 community-based services, using a managed care model. Unless
 1510 otherwise specified, the provisions of ss. 409.961-409.970 apply
 1511 to the long-term care managed care program for persons with
 1512 developmental disabilities.
 1513 (3) The Agency for Persons with Disabilities shall assist
 1514 the agency to develop the specifications for use in the
 1515 invitations to negotiate and the model contract; determine
 1516 clinical eligibility for enrollment in long-term care plans for
 1517 persons with developmental disabilities; assist the agency to
 1518 monitor plan performance and measure quality; assist clients and
 1519 families to address complaints with the plans; facilitate
 1520 working relationships between plans and providers serving
 1521 persons with developmental disabilities; and perform other
 1522 functions specified in a memorandum of agreement.

BILL

ORIGINAL

YEAR

1523 Section 29. Section 409.987, Florida Statutes, is created
 1524 to read:

1525 409.987 Eligibility.-

1526 (1) Medicaid recipients who meet all of the following
 1527 criteria are eligible and will be enrolled in a comprehensive
 1528 long-term care plan or long-term care plan:

1529 (a) Medicaid eligible pursuant to s.409.904.

1530 (b) A Florida resident who has a developmental disability
 1531 as defined in s. 393.063.

1532 (c) Meets the level of care need including:

1533 1. The recipient's intelligence quotient is 59 or less;

1534 2. The recipient's intelligence quotient is 60-69,
 1535 inclusive, and the recipient has a secondary condition that
 1536 includes cerebral palsy, spina bifida, Prader-Willi syndrome,
 1537 epilepsy, or autistic disorder; or ambulation, sensory, chronic
 1538 health, and behavioral problems;

1539 3. The recipient's intelligence quotient is 60-69,
 1540 inclusive, and the recipient has severe functional limitations
 1541 in at least three major life activities including self-care,
 1542 learning, mobility, self-direction, understanding and use of
 1543 language, and capacity for independent living; or

1544 4. The recipient is eligible under a primary disability of
 1545 autistic disorder, cerebral palsy, spina bifida, or Prader-Willi
 1546 syndrome. In addition, the condition must result in substantial
 1547 functional limitations in three or more major life activities,
 1548 including self-care, learning, mobility, self-direction,
 1549 understanding and use of language, and capacity for independent
 1550 living.

BILL

ORIGINAL

YEAR

1551 (d) Meets the level of care need for services in an
 1552 intermediate care facility for the developmentally disabled.

1553 (e) Is enrolled in a home and community based Medicaid
 1554 waiver established in chapter 393, or the Consumer Directed Care
 1555 Plus program for persons with developmental disabilities under
 1556 the Medicaid state plan or the recipient is a Medicaid-funded
 1557 resident of a private intermediate care facility for the
 1558 developmentally disabled on the date the managed long-term care
 1559 plans for persons with disabilities become available in the
 1560 recipient's region or the recipient has been offered enrollment
 1561 in a comprehensive long-term care plan or long-term care plan.

1562 1. The Agency for Persons with Disabilities shall make
 1563 offers for enrollment to eligible individuals based on the
 1564 waitlist prioritization in s.393.065(5) and subject to
 1565 availability of funds. Prior to enrollment offers, the agency
 1566 shall determine that sufficient funds exist to support
 1567 additional enrollment into plans.

1568 (2) Unless specifically exempted, all eligible persons
 1569 must be enrolled in a comprehensive long-term care plan or a
 1570 long-term care plan. Medicaid recipients who are residents of a
 1571 developmental disability center, including Sunland Center in
 1572 Marianna and Tacachale Center in Gainesville, are exempt from
 1573 mandatory enrollment but may voluntarily enroll in a long-term
 1574 care plan.

1575 Section 30. Section 409.988, Florida Statutes, is created
 1576 to read:

1577 409.988 Benefits.-Managed care plans shall cover, at a
 1578 minimum, the services in this section. Plans may customize

BILL

ORIGINAL

YEAR

1579 benefit packages or offer additional benefits to meet the needs
 1580 of enrollees in the plan.
 1581 (1) Intermediate care for the developmentally disabled.
 1582 (2) Services in alternative residential settings,
 1583 including, but not limited to:
 1584 (a) Group homes and foster care homes licensed pursuant to
 1585 chapters 393 and 409.
 1586 (b) Comprehensive transitional education programs licensed
 1587 pursuant to chapter 393.
 1588 (c) Residential habilitation centers licensed pursuant to
 1589 chapter 393.
 1590 (d) Assisted living facilities, and transitional living
 1591 facilities licensed pursuant to chapters 400 and 429.
 1592 (3) Adult day training.
 1593 (4) Behavior analysis services.
 1594 (5) Companion services.
 1595 (6) Consumable medical supplies.
 1596 (7) Durable medical equipment and supplies.
 1597 (8) Environmental accessibility adaptations.
 1598 (9) In-home support services.
 1599 (10) Therapies, including occupational, speech,
 1600 respiratory, and physical therapy.
 1601 (11) Personal care assistance.
 1602 (12) Residential habilitation services.
 1603 (13) Intensive behavioral residential habilitation
 1604 services.
 1605 (14) Behavior focus residential habilitation services.
 1606 (15) Residential nursing services.

BILL ORIGINAL YEAR

1607 (16) Respite care.
 1608 (17) Case management.
 1609 (18) Supported employment.
 1610 (19) Supported living coaching.
 1611 (20) Transportation.
 1612 Section 31. Section 409.989, Florida Statutes, is created
 1613 to read:
 1614 409.989 Qualified plans.—
 1615 (1) ELIGIBLE PLANS.—Provider service networks may be
 1616 either long-term care plans or comprehensive long-term care
 1617 plans. Other plans must be comprehensive long-term care plans
 1618 and under contract to provide services pursuant to s. 409.973 or
 1619 s. 409.980 in any of the regions which form the combined region
 1620 as defined in this section.
 1621 (2) PROVIDER SERVICE NETWORKS.—Provider service networks
 1622 targeted to serve persons with disabilities must include one or
 1623 more owners licensed pursuant to s. 393.067 or s. 400.962 and
 1624 with at least 10 years experience in serving this population.
 1625 (3) ELIGIBLE PLAN SELECTION.—The agency shall select
 1626 eligible plans through the procurement described in s. 409.966.
 1627 The agency shall notice invitations to negotiate no later than
 1628 January 1, 2015
 1629 (a) The agency shall procure at least two plans and no
 1630 more than three plans for services in combined Regions I and II.
 1631 At least one plan shall be a provider service network, if any
 1632 submit a responsive bid.
 1633 (b) The agency shall procure at least two plans and no
 1634 more than three plans for services in combined Regions III and

BILL

ORIGINAL

YEAR

1635 IV. At least one plan shall be a provider service network, if
 1636 any submit a responsive bid.

1637 (c) The agency shall procure at least two plans and no
 1638 more than four plans for services in combined Regions V, VI and
 1639 VII. At least one plan shall be a provider service network, if
 1640 any submit a responsive bid.

1641
 1642 If no provider service network submits a responsive bid, the
 1643 agency shall procure no more than one less than the maximum
 1644 number of eligible plans permitted in the combined region.
 1645 Within 12 months after the initial invitation to negotiate, the
 1646 agency shall attempt to procure an eligible plan that is a
 1647 provider service network. The agency shall notice another
 1648 invitation to negotiate only with provider service networks in
 1649 such combined region where no provider service network has been
 1650 selected.

1651 (4) QUALITY SELECTION CRITERIA.—In addition to the
 1652 criteria established in s. 409.966, the agency shall consider
 1653 the following factors in the selection of eligible plans:

1654 (a) Specialized staffing. Plan employment of executive
 1655 managers with expertise and experience in serving persons with
 1656 developmental disabilities.

1657 (b) Network qualifications. Plan establishment of a
 1658 network of service providers dispersed throughout the combined
 1659 region and in sufficient numbers to meet specific accessibility
 1660 standards established by the agency for specialty services for
 1661 persons with developmental disabilities.

BILL

ORIGINAL

YEAR

1662 (c) Evidence that an eligible plan has written agreements
 1663 or signed contracts or has made substantial progress in
 1664 establishing relationships with providers prior to the plan
 1665 submitting a response. The agency shall give preference to plans
 1666 with evidence of signed contracts with providers listed in s.
 1667 409.990 (2) (a) - (b) .

1668 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's
 1669 Medical Services Network may provide either long-term care plans
 1670 or comprehensive long-term care plans. Participation by the
 1671 Children's Medical Services Network shall be pursuant to a
 1672 single, statewide contract with the agency not subject to the
 1673 procurement requirements or regional plan number limits of this
 1674 section. The Children's Medical Services Network must meet all
 1675 other plan requirements.

1676 Section 32. Section 409.990, Florida Statutes, is created
 1677 to read:

1678 409.990 Managed care plan accountability.—In addition to
 1679 the requirements of s. 409.967, managed care plans and providers
 1680 shall comply with the requirements of this section.

1682 (2) PROVIDER NETWORKS.—Managed care plans may limit the
 1683 providers in their networks based on credentials, quality
 1684 indicators, and price. However, in the first contract period
 1685 after an eligible plan is selected in a region by the agency,
 1686 the plan must offer a network contract to the following
 1687 providers in the region:

1688 (a) Providers with licensed institutional care facilities
 1689 for the developmentally disabled.

BILL

ORIGINAL

YEAR

1690 (b) Providers of alternative residential facilities
 1691 specified in s.409.988.

1692
 1693 After 12 months of active participation in a managed care plan
 1694 network, the plan may exclude any of the above-named providers
 1695 from the network for failure to meet quality or performance
 1696 criteria. If the plan excludes a provider from the plan, the
 1697 plan must provide written notice to all recipients who have
 1698 chosen that provider for care. The notice shall be issued at
 1699 least 90 days before the effective date of the exclusion.

1700 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1701 this subsection, providers may limit the managed care plans they
 1702 join. Licensed institutional care facilities for the
 1703 developmentally disabled and licensed residential settings
 1704 providing Intensive Behavioral Residential Habilitation services
 1705 with an active Medicaid provider agreement must agree to
 1706 participate in any eligible plan selected by the agency

1707 (4) PERFORMANCE MEASUREMENT.—Each managed care plan shall
 1708 monitor the quality and performance of each participating
 1709 provider. At the beginning of the contract period, each plan
 1710 shall notify all its network providers of the metrics used by
 1711 the plan for evaluating the provider's performance and
 1712 determining continued participation in the network.

1713 (5) PROVIDER PAYMENT.—Managed care plans and providers
 1714 shall negotiate mutually acceptable rates, methods, and terms of
 1715 payment. Plans shall pay intermediate care facilities for the
 1716 developmentally disabled and intensive behavior residential

BILL ORIGINAL YEAR

1717 habilitation providers an amount equal to the facility-specific
 1718 payment rate set by the agency.

1719 (6) CONSUMER AND FAMILY INVOLVEMENT.—Each managed care
 1720 plan must establish a family advisory committee to participate
 1721 in program design and oversight.

1722 (7) Consumer-Directed Care. - Each managed care plan must
 1723 offer consumer-directed care services to enrollees pursuant to
 1724 s. 409.221.

1725 Section 33. Section 409.991, Florida Statutes, is created
 1726 to read:

1727 409.991 Managed care plan payment.—In addition to the
 1728 payment provisions of s. 409.968, the agency shall provide
 1729 payment to comprehensive long-term care plans and long-term care
 1730 plans pursuant to this section.

1731 (1) Prepaid payment rates shall be negotiated between the
 1732 agency and the eligible plans as part of the procurement
 1733 described in s. 409.966.

1734 (2) Payment for comprehensive long-term care plans
 1735 covering services pursuant to s. 409.973 shall be blended with
 1736 payments for long-term care plans for services specified in s.
 1737 409.988.

1738 (3) Payment rates for plans covering service specified in
 1739 s. 409.988 shall be based on historical utilization and spending
 1740 for covered services projected forward and adjusted to reflect
 1741 the level of care profile of each plan's enrollees.

1742 (4) The Agency for Persons with Disabilities shall conduct
 1743 the initial assessment of an enrollee's level of care. The
 1744 evaluation of level of care shall be based on assessment and

BILL

ORIGINAL

YEAR

1745 service utilization information from the most recent version of
 1746 the Questionnaire for Situational Information and encounter
 1747 data.

1748 (5) The agency shall assign enrollees of developmental
 1749 disabilities long-term care plans into one of five levels of
 1750 care to account for variations in risk status and service needs
 1751 among enrollees.

1752 (a) Level of care 1 consists of individuals receiving
 1753 services in an intermediate care facility for the
 1754 developmentally disabled.

1755 (b) Level of care 2 consists of individuals with intensive
 1756 medical or adaptive needs and that are essential for avoiding
 1757 institutionalization, or who possess behavioral problems that
 1758 are exceptional in intensity, duration, or frequency and present
 1759 a substantial risk of harm to themselves or others.

1760 (c) Level of care 3 consists of individuals with service
 1761 needs, including a licensed residential facility and a moderate
 1762 level of support for standard residential habilitation services
 1763 or a minimal level of support for behavior focus residential
 1764 habilitation services, or individuals in supported living who
 1765 require more than 6 hours a day of in-home support service.

1766 (d) Level of care 4 consists of individuals requiring less
 1767 than moderate level of residential habilitation support in a
 1768 residential placement, or individuals in supported living who
 1769 require 6 hours a day or less of in-home support service.

1770 (e) Level of care 5 consists of individuals who do not
 1771 receive in-home support service and need minimal support

BILL ORIGINAL YEAR

1772 services while living in independent or supported living
 1773 situations or in their family home.

1774
 1775 The agency shall periodically adjust aggregate payments to plans
 1776 based on encounter data to account for variations in risk levels
 1777 among plans' enrollees.

1778 (6) The agency shall establish intensive behavior
 1779 residential habilitation rates for providers approved by the
 1780 agency to provide this service. The agency shall also establish
 1781 intermediate care facility for the developmentally disabled-
 1782 specific payment rates for each licensed intermediate care
 1783 facility. Payments to intermediate care facilities for the
 1784 developmentally disabled and providers of intensive behavior
 1785 residential habilitation service shall be reconciled to
 1786 reimburse the plan's actual payments to the facilities.

1787 Section 34. Section 409.992, Florida Statutes, is created
 1788 to read:

1789 409.992 Automatic enrollment.-

1790 (1) The agency shall automatically enroll into a
 1791 comprehensive long-term care plan or a long-term care plan those
 1792 Medicaid recipients who do not voluntarily choose a plan
 1793 pursuant to s. 409.969. The agency shall automatically enroll
 1794 recipients in plans that meet or exceed the performance or
 1795 quality standards established pursuant to s. 409.967, and shall
 1796 not automatically enroll recipients in a plan that is deficient
 1797 in those performance or quality standards. The agency shall
 1798 assign individuals who are deemed dually eligible for Medicaid
 1799 and Medicare, to a plan that provides both Medicaid and Medicare

BILL

ORIGINAL

YEAR

1800 services. The agency may not engage in practices that are
 1801 designed to favor one managed care plan over another. When
 1802 automatically enrolling recipients in plans, the agency shall
 1803 take into account the following criteria:
 1804 (a) Whether the plan has sufficient network capacity to
 1805 meet the needs of the recipients.
 1806 (b) Whether the recipient has previously received services
 1807 from one of the plan's home and community-based service
 1808 providers.
 1809 (c) Whether home and community-based providers in one plan
 1810 are more geographically accessible to the recipient's residence
 1811 than those in other plans.
 1812 Section 35. This act shall take effect July 1, 2011.